Arizona Department of Health Services Office for Children with Special Health Care Needs Children's Rehabilitative Services Administration	**Effective Date: 08/01/2007** **Last Review Effective Date: 02/13/2008**
SUBJECT: Grievance System	SECTION: GS 1.1

SUBTITLE: CRSA Non-quality of Care/ Grievance Process

POLICY:

It is the policy of Children's Rehabilitative Services Administration (CRSA) to assure timely, responsive, and effective processes for all grievances filed. CRSA Quality Management performs an investigation of all non-quality of care issues, which includes an investigation, analysis, intervention, evaluation, resolution, reporting, closure, and trending process as well as oversight of the process for grievances received by the CRS Contractors.

STANDARD:

Children's Rehabilitative Services Administration (CRSA), Quality Management Division receives and is responsible for ensuring timely and appropriate resolution of non-quality of care grievances brought by CRS members, providers, AHCCCS, ADHS Director, Governors Office, and other agencies.

DEFINITIONS:

Action:
The denial or limited authorization of a requested service including:

1) The type or level of service;
2) The reduction, suspension, or termination of a previously authorized service;
3) The denial, in whole or in part, of payment for a service;
4) The failure to provide a service in a timely manner as set forth in contract;
5) The failure of a contractor to act within the time frame specified in this Policy; or
6) The denial of a rural CRS member's request to obtain services outside CRSA or its subcontractors' network under 42 CFR 438.52(b)(2)(ii), when CRSA or its subcontractors is the only contractor in the rural area.

Assess or Evaluate:
The process used to examine and determine the level of quality or the progress toward improvement of quality and/or performance related to CRS Contractor service delivery systems.

Appeal:

A request to review an action.

Corrective Action Plan (CAP):
A written work plan that includes goals and objectives, steps to be taken and methodologies to be used to accomplish CAP goals and objectives, and staff responsible to carry out the CAP within established timelines. CAPs are generally used to improve performance of the CRS Contractors, to enhance QM/PI activities and the outcomes of the activities, or to resolve a deficiency.

Grievance:
An expression of dissatisfaction about any matter other than an action. Possible subjects for grievances include, but are not limited to:

1) The quality of care or services provided; and
2) Aspects of interpersonal relationships such as rudeness of a provider or employee or failure to respect the enrollee's rights.

Grievance Log: Quality and non-quality of care concerns submitted by contractors.

Level of Severity:
The designation of a quality of care issue as to degree of life threat, disability or other adverse outcome.

Non-Quality of Care Concern:
The grievance has no possibility of impacting the member's health care status.

Quality of Care Concern:
If there is any possibility that the grievance could impact the member's health care status in any way, it must be treated as a quality of care concern.

Quality of Care Database:
The database where all CRSA grievances and potential quality of care review and referrals are entered for monitoring, tracking, and trending purposes.

PROCEDURE:

The CRSA quality management coordinator is responsible for facilitating the investigation, analysis, intervention, evaluation, resolution, reporting, closure, and trending of non-quality of care grievances received within the CRS system and reporting to the CRSA Quality Management Committee (QMC). The processes explained in this policy include:

1) CRSA Direct Grievances for Non-Quality of Care Concerns;

2) CRSA Oversight of CRS Contractor Grievances for Non-Quality of Care Concerns;

3) Grievance Log Review;

4) Tracking and Trending; and

5) Priority Category of Grievances.

CRSA DIRECT GRIEVANCES for Non-Quality of Care Concerns:

When CRSA receives a grievance from a member, provider, or referral source and the grievance has no possibility of impacting the members health care status, the CRSA quality management coordinator:

1) Opens the case in the Quality of Care (QOC) Database as a non-quality of care concern including:
   a) Date grievance received;
   b) Date case opened;
   c) Demographics;
   d) Method of receipt of grievance; and
   e) Description of grievance.

2) Sends the non-quality of care acknowledgement letter (Attachment 1) to the grievant within five (5) days;

   Most grievances should be resolved within 10 business days of receipt, but in no case longer than 90 days;

3) Documents all steps utilized during investigation and resolution process;

4) Sends non-quality of care closure/resolution letter that provides sufficient detail to ensure that the member has an understanding of the resolution of their issue, any responsibilities they have in ensuring all covered, medically necessary care needs are met, and a contact name/telephone number to call for assistance or to express any unresolved concerns;

5) Documentation of implemented corrective action plan(s) or action(s) taken to resolve the concern;

6) Enters the data in the QOC Database for evaluation and analysis; and

7) Reports any trends from non-quality of care concerns that have a potential for quality of care concerns to the CRSA Quality Management Committee.

Quality of Care Concerns:

All Quality of Care concerns will be resolved in compliance with CRSA Policy QM 1.5, CRSA Quality of Care Process.

CRSA OVERSIGHT OF CRS CONTRACTOR GRIEVANCES

CRS Contractors are required to log all non-quality of care and quality of care grievances (severity levels 0-4) within the Grievance Log. The Logs must be submitted to CRSA via the secured FTP server by the 15th of every month for the previous month. CRSA reviews the Grievance Logs monthly.

Grievance Log Review

CRSA reviews the CRS Contractors Grievance Logs monthly for timeliness, accuracy, and appropriateness of grievance processing. Trended issues are discussed at the CRSA Quality Management Committee.

If, from the Grievance Log reviews of severity level 0 cases, CRSA requires further information, the CRSA Quality Management Coordinator:

1) Notifies the CRSA Medical Director and the CRSA Medical Director reviews and analyzes the findings and proposed resolution from the CRS Contractor and may discuss findings with the CRS Contractor Medical Director; and/or
   a) Accepts CRS Contractor Medical Director's decision;
   b) Refers provider quality of care issues to the CRSA Peer Review Committee; and
   c) Determine interventions, including corrective action plans.

2) Documents in the existing case file, in the QOC Database, that CRSA is requesting additional information, including the:
   a) Date of letter to the CRS Contractor; and
   b) Expected date of response to CRSA.

3) Requests a response from the CRS Contractor:
   The CRS Contractor's findings including any proposed steps for resolution must be returned within a specified timeframe.

4) Requests medical records, if applicable;

5) Sends closure letter to CRS contractor; and

6) Documents resolution in the QOC Database.

Tracking and Trending

Monthly grievance logs from contractors will be compiled into the CRSA Quality of Care database. Information will be compiled into the QOC Database and will be evaluated

and analyzed quarterly for trends. Quarterly reports will be submitted to the CRSA Quality Management Committee.

1) Quarterly reports include:
   a) Number of cases by:
      i) Main category;
      ii) Sub category;
      iii) Initial severity level; and
      iv) Closing severity level.
   b) Types and numbers/percentages of substantiated, unsubstantiated and unable to substantiate non-quality of care issues; and
   c) Interventions implemented to resolve and prevent similar incidences.

All non-quality of care reports will be sent to AHCCCS as requested.

If significant negative trends are noted, CRSA may consider making it a CRSA or CRS Contractor performance improvement project or other performance improvement activity.

If at any time CRSA deems that systemic improvement is required to improve processes, the responsible CRS Contractor is notified in writing of the need for a corrective action plan (CAP) to prevent further occurrences. CAPs from CRS Contractors must include the following:

   a) A description of the problem which requires improvement;
   b) Improvement action to be taken along with the responsible Contractor personnel assignment; and
   c) Time frames for implementation; and monthly evaluation of progress towards goals.

CRSA monitors the corrective action plans and if the interventions and/or the corrective actions are not improving the process, CRSA may assign new interventions, impose sanctions and/or other activities as identified by the CRSA Quality Management Committee to the CRS Contractor.

PRIORITY CATEGORY OF GRIEVANCES

Grievance priorities are categorized in four groups:

1) High Risk- Including situations of immediate jeopardy to the member; abuse and neglect; inadequate or inappropriate care of an acute condition; denial of services deemed medically necessary by the member/provider; unexpected deaths; potential provider misconduct; issues with, or the potential for, adverse media coverage or the potential for a lawsuit; and issues referred by the AHCCCSA, ADHS Director's Office and or the Governor's Office.

2) Routine- Including slow, or no responsiveness to a request for evaluation, treatment or other request; potential unsafe home environment; member rights

violation; inadequate case management; availability/timeliness of transportation for medical appointments; non-compliance with appointment scheduling or wait time requirements; need for information or referral to resolve an issue. If there is absolutely no possibility that the complaint could impact the member in any way, it is to be tracked only, as a general grievance.

3) Track and Trend- Including non-quality-of-care concerns that may become quality of care concerns if a trend is identified.

4) Referral to other OCSHCN Sections, or other Agencies- Including eligibility issues; contract compliance; network issues; member fraud; compliance with statute or state plan; abuse or neglect; compliance with licensure standards; criminal offenses; etc. Fraud, abuse, neglect and criminal offenses are to be referred to the appropriate agency immediately upon identification.

Approved:	Date:
CRSA Administrator	2/18/08
CRSA Medical Director	Date: 2/19/08